STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Augustana Health Care Center of Apple Valley
Survey Exit Date: November 10, 2010

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on December 2, 2011. The record of the Office of Administrative Hearings (OAH) closed after the facility's submission of additional materials on December 9, 2011.

Chris Campbell, IIDR Coordinator, Licensing and Certification Program, Division of Compliance Monitoring (Division), P.O. Box 64900, St. Paul, MN 55164-0900, appeared for the Division. Mary Cahill, Department of Health, also participated in the conference.

Robert Rodè and Rebecca Coffin, Voigt, Rodè & Boxeth, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114 appeared for Augustana Health Care Center of Apple Valley (facility). Jolene MacDonald, Director of Nursing; Theresa Graham, Director of Staff Development and Education; David Shaw, Administrator; and Peggy Fossen, RN, LPN, Legal Nurse Consultant, also participated in the conference on behalf of the facility.

FINDINGS OF FACT

1. On November 10, 2010, the Division issued a Statement of Deficiencies to the facility, citing Tag F 323[1] and Tag F 498[2] at a scope and severity level of G, actual harm with isolated scope. The facility's allegedly deficient practices pertain to Resident # 1, who fell to the floor and was injured when two nursing assistants were attempting to transfer her from her bed to a bath chair using a mechanical lift.[3]

[1] This tag alleges a violation of 42 C.F.R. § 483.25(h), quality of care, provision of an environment that remains as free as possible from accident hazards and provision of adequate supervision and assistance devices to reduce the risk of falls.
[2] This tag alleges a violation of 42 C.F.R. § 483.75(f), proficiency of nurse aides.
[3] MDH Ex. E-1, Form 2567.

2. Resident #1 is a 69-year-old woman who has osteoporosis, end-stage multiple sclerosis, contractures, and spasms. Resident #1 also has a history of urinary tract infections. She is fed with a gastric tube. She is unable to communicate and has severely impaired cognition and is totally dependent on staff for all activities of daily living. She is transferred with the assistance of two persons using a mechanical lift.[4] She takes daily medication to control involuntary movements.[5] She has lived at the facility for approximately six years.[6]

3. Resident #1's care plan provides that she is to be transferred with the assistance of two persons using a mechanical lift.[7] The facility assessed the propriety of using the lift to transfer the resident on a quarterly basis and found it continued to be appropriate given the resident's poor trunk control and involuntary movements.[8]

4. The facility uses "Uno" lifts manufactured by Liko for transferring residents, and prior to early 2010, used lime-green Liko slings with the lifts. The manufacturer's usage directions provide explicit directions for placing the sling and further provide that after connecting the sling to the sling bar, caregivers are to check to ensure the straps are fully attached.[9] The instructions for the Liko universal sling also specifically provide that:

> Although Liko's sling bars are equipped with safety latches, special caution must be exercised: Before the patient is lifted from the underlying surface, but after the straps have been fully extended, make sure the straps are properly connected to the sling bar.[10]

5. The facility's training materials also called for the use of a Liko lift with a Liko lift sling. The materials further provide that staff members are to be sure the sling is positioned correctly according to the Liko Universal Sling instruction guide, with the bottom edge of the sling positioned evenly with a resident's tailbone. The Liko Universal Sling instruction guide recommends which Liko universal slings are appropriate for use with various Liko sling bars, depending on the size and type of the sling and the width and design of the sling bar. It further provides that combinations of accessories/products other than those recommended by Liko can result in risks for the safety of the patient.[11]

6. The facility's training materials did not specifically address the need to ensure that the clips holding the sling straps on the sling bar are securely closed.[12]

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[4] MDH Ex. E-1.
[5] Facility Ex. 2; Facility Ex. 3.
[6] Facility Ex. 8.
[7] Facility Ex. 3 (care plan problem 2).
[8] Facility Ex. 1.
[9] MDH Exs. L & S.
[10] MDH Ex. V-2.
[11] MDH Ex. V-8.
[12] Facility Ex. 12; MDH Ex. H-41.

7. Staff members involved in transferring Resident #1 received training on procedures for transfers using the lime-green Liko slings. The facility had policies and procedures in place to prevent and reduce accidents associated with assistive devices used in transferring residents.[13]

8. In January 2010, the director of nursing ordered replacement slings after staff had pointed out that the Liko slings were becoming worn. The director of nursing ordered Hoyer-brand universal slings to use on the Liko lift.[14] The website consulted by the director of nursing provides information to determine which Hoyer slings are compatible with various Hoyer lifts; it does not provide (contrary to the facility's position) that Hoyer slings may be used with lifts manufactured by other companies.[15]

9. The facility's director of staff education was not aware that Hoyer slings were ordered for or being used with the Liko lifts.[16] The decision to use Hoyer slings with Liko lifts is not consistent with the facility's training materials used to assess competency of staff.[17]

10. The sling bar at the top of a Hoyer lift is shaped somewhat differently than the sling bar at the top of a Liko lift; in addition, the loop straps at the shoulder of Hoyer universal slings are longer than those on Liko universal slings.[18]

11. Beginning in about March 2010, the facility used a dark-green Hoyer universal sling model number 70012 for transferring the resident.[19] The sling was the proper size for the resident and had the head support required for patients with poor upper body strength. The sling remained in the resident's room when it was not being used.[20]

12. At about 8:00 p.m. on September 8, 2010, two nursing assistants were helping to transfer Resident #1 from her bed to a tub chair. She fell out of the sling, and her head hit the floor. The resident was sweating, and she had difficulty breathing and a weak pulse. After receiving oxygen, the resident's vital signs stabilized. The facility immediately contacted her family and physician to report the fall. The physician recommended monitoring the resident for changes in status, which the facility did.[21]

13. The facility's initial investigation concluded that that the Hoyer sling was not positioned correctly on the resident and was not placed far enough back on the resident's thigh. When one of the nursing assistants attempted to hold the resident in the cradle position to guide her into the chair, one of the sling loops came off the sling

[13] Facility Exs. 15 & 19; MDH Ex. K-1.
[14] Facility Ex. 22.
[15] Facility Exs. 13 & 14. *See also* http://www.joerns.com/pdfs_products/patient-handling/chla2/jhc_classic-lift_brochure.pdf (You must use Hoyer slings with Hoyer lifts).
[16] Statement of Theresa Graham.
[17] MDH Ex. H-41.
[18] *Compare* MDH Ex. I-3 (Hoyer) *with* MDH M-1, V-1 (Liko).
[19] Facility Ex. 22.
[20] Statement of Jolene MacDonald.
[21] Facility Exs. 5 & 6; MDH Ex. H-31.

bar, and she fell through to the floor. Further investigation with more interviews and re-enactment of the incident by staff confirmed that the sling was not placed properly during the transfer.[22]

14. On September 14, 2010, the facility reported the fall to OHFC.[23] According to the report, the nursing assistants were using the correctly sized sling; staff members performing the transfer were following policy and procedure with regard to the lift; the resident's care plan was followed; and no abuse or neglect was suspected. The report provided that the facility would continue its effort to find the root cause of the fall.[24]

15. On the same date, the facility sent Resident #1 to the emergency room when she began running a temperature and appeared to be more lethargic.[25]

16. At the hospital, a CT scan of the resident's head showed subdural and intra-parenchymal bleeding and edema on the left side with possible occipital skull fracture. She was also treated for a urinary tract infection. She returned to the facility the same afternoon with physician orders to elevate the head of her bed and to remain on bed rest.[26] Because she was grimacing, nursing staff believed she was in pain, and her physician prescribed a narcotic pain medication.[27] Her level of consciousness improved over the next few weeks, and as of October 28, 2010, her physician determined she had returned to her baseline status.[28]

17. On September 16, 2010, the facility inspected all mechanical lifts to ensure they were operating properly.[29] On September 17 and 20, 2010, the nursing assistants received additional education regarding the use of mechanical lifts and slings. They were instructed to check for proper alignments and make sure that straps were attached.[30]

18. The facility had no prior incidents relating to the use of mechanical lifts or slings.[31]

19. When investigators interviewed staff members on September 30, 1010, and October 1, 2010, they indicated that they were not familiar with and had not been trained on the use of the dark green sling.[32]

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[22] MDH Ex. H-4; Facility Ex. 17 at 5-6.
[23] Facility Ex. 8.
[24] *Id.*
[25] *Id.*; MDH Ex. H-28.
[26] Facility Ex. 10; MDH Ex. H-26-27, H-34.
[27] Facility Ex. 4 at p. 2.
[28] Facility Ex. 11.
[29] MDH Ex. H-36.
[30] Facility Ex. 9; MDH Ex. H-39 & H-40.
[31] Facility Ex. 17 at 7.
[32] MDH Ex. E-5.

20. The Department's OHFC initially made a determination of neglect against the facility under the Vulnerable Adults Act, Minn. Stat. § 626.557 (2010). Upon reconsideration, the OHFC changed the determination to inconclusive on the basis that the evidence was insufficient to show that training requirements between the slings previously used and the newly purchased slings would be significantly different.[33]

21. After being cited by OHFC, the facility replaced the Hoyer slings with Liko slings.[34]

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The citation with regard to Tags F323 and F498 are supported by the facts and should be AFFIRMED as to scope and severity.

Dated: December 16, 2011

s/Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digital recording (no transcript)

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

The Division issued these citations at a scope and severity of actual harm, isolated occurrence. The facility vigorously challenges the finding that its practices were deficient, maintaining that it substantially complied with the regulations.

Tag F 323

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial

[33] Facility Ex. 20.
[34] Facility Ex. 23; MDH Ex. H-38; MDH Ex. V.

well-being, in accordance with the comprehensive assessment and plan of care.[35] The facility must ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.[36] The intent of this provision is to ensure that the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.[37]

An "unavoidable accident" is one that occurs despite the facility's efforts to identify environmental hazards and individual resident risks; an "avoidable accident" is one that occurs because the facility has failed to identify environmental hazards and individual resident risks.[38] Assistive devices may be hazardous when they are used improperly (i.e., in a manner that is not in accordance with manufacturer's recommendations or current standards of practice).[39] Training on the proper use of assistive devices is crucial to prevent accidents.[40]

Section 483.25 does not make a facility strictly liable for accidents that occur, but it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents.[41]

The facility contends that the findings on form 2567 regarding employee training on a specific type of sling are inappropriate because its training program applied to all types and brands of slings and because the two nursing assistants involved in this incident received the required training. The Administrative Law Judge agrees that it was not necessary to train the employees on the use of the Hoyer sling, not because all training is the same for all slings, but because the lift manufacturer did not recommend the use of this type of sling, and it should not have been used at all.

In this case, the facility's director of nursing clearly failed to understand the significance of using a sling not recommended by the lift manufacturer and the importance of ensuring that a particular sling (even one made by the manufacturer of the lift) is compatible with the design of the sling bar, so that the sling holds residents in the proper position when they are transferred. Although it is unclear from this record how the design or shape of the sling may have contributed to the incident, it is clear that use of the Hoyer sling was inconsistent with the facility's own training materials. For these reasons, it cannot be said that the facility took all reasonable steps to provide assistance devices that met the resident's needs and mitigated foreseeable risks of

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[35] 42 C.F.R. § 483.25.
[36] 42 C.F.R. § 483.25 (h)(1) & (2).
[37] Ex. F-1 (State Operations Manual).
[38] Ex. F-1 & F-2.
[39] MDH Ex. F-10, F-20.
[40] Ex. F-14.
[41] *Odebolt Nursing & Rehabilitation Center v. Centers for Medicare & Medicaid*, Docket No. C-04-262 (Dep't App. Bd. Mar. 13, 2007) (http://www.hhs.gov/dab/decisions/CR1574.html).
Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003).

harm. The record supports the Division's citation of this deficient practice, although the references to lack of training on the Hoyer sling should be deleted from the findings.

Tag F 498

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care.[42] In the form 2567, the findings again suggest that the care was deficient because the nursing assistants were not trained on the use of the Hoyer sling.

This citation addresses the proficiency of the care actually provided to the resident, not the adequacy of the employee training program. The facility's own investigation concluded that the incident occurred at least in part because the nursing assistants failed to place the sling properly during the transfer and because the sling loops were not properly connected to the sling bar. This citation is supported by the record, but again the references to lack of training on the use of a Hoyer sling should be deleted from the 2567.

Actual Harm

Resident # 1 did suffer actual harm in the form of subdural and intra-parenchymal bleeding and edema on the left side with a possible occipital skull fracture. She had diminished consciousness for several weeks, and she had pain treated with narcotic medications after this incident. Although the resident eventually did return to her baseline status, the determination of actual harm should be affirmed.

K. D. S.

[42] 42 C.F.R. § 483.75(f).